The "Carrier" in Government Medical Care Plans

RICHARD S. WILBUR, M.D., *Palo Alto*

PASSAGE OF THE Medicare and Medicaid law in 1965 drastically altered our whole system of medical care. An integral part of this same law, P.L. 89-97, was the use of what the law calls a "carrier" to handle the means of payment for those who provide services under these medical care plans. What is a carrier, and who needs it? Is there really any need for this third party—this middleman—this extra step and expense in the already complex relationships between government and the providers of service?

The carrier specified by P.L. 89-97 must be a private organization, with previous experience in handling prepayment health care plans. It must have covered a significant number of policy beneficiaries in the area it is to serve. Its function is to supervise the proper distribution, subject to government regulation and audit, of the health care funds of the program. These are distributed to the providers of service — the physicians, dentists, druggists, optometrists and all others who care for patients, or to the beneficiaries (the patients) as under Medicare.

The first reason for using the carrier is simply that the necessity of setting up these enormous programs in a short period demanded the use of a preexisting mechanism. The administration of Medicare directly by government would have required the establishment within a year of a massive new bureau composed entirely of people with little or no experience in the processing of health care claims. The alternative of turning to experienced private enterprises with a long history of handling such claims on a private basis meant that the program could be initiated sooner and with far less difficulty. The use of a carrier by government was not a new idea with P.L. 89-97. For instance, California Physicians' Service worked successfully in similar functions under various government programs since World War II.

In California, Blue Shield (CPS), both Blue Cross Plans and the Occidental Insurance Company all had qualified managers and supervisors to train the newly hired personnel needed by expansion. These key people, who knew claims processing, were able to train newly hired clerks in a way in which no state or federal government agency could possibly have done.

Not all government agencies chose to use this efficient system, unfortunately. Whereas in California, Blue Shield implemented the Title XIX Program for the entire state with the addition of 1,300 employees, New York City attempted to implement its Medicaid Program by the use of its own welfare department, and for that one city alone hired 3,000 new employees. California Blue Shield pays the vast majority of Medi-Cal claims within a period of 30 days, while New York City is still attempting to pay claims within a period of less than six months, and has finally begun negotiating with the local Blue Shield Plan to straighten out its problems.

The use of an already existing mechanism not only leads to the rapid institution of efficient and economical claims processing, but makes use of personnel who have developed knowledge from long experience with patterns of practice, and with reasonable costs and charges. They are able, as well, on a continuing basis, to compare those fees submitted under government-financed plans with those from their standard business. Usual and customary fees could not be implemented by a government bureau, for it would not only be inexperi-

The author is chairman of the board of California Blue Shield.
Submitted 22 January 1968.
Reprint requests to: 300 Homer Avenue, Palo Alto 94301.

enced in claims processing, but would also lack a background of fee evaluation experience to draw upon. Thus the use of the carrier eliminated the need for a fee schedule at the inception of both Medicare and Medi-Cal. Furthermore, the use of the carrier means that one private organization, which handles its own standard commercial program in addition to Medicare, Medi-Cal and the CHAMPUS† Military Dependents' Program, may use the experience from each as a measure for the others. This not only provides a valuable cross-check, but at the same time removes the necessity for each of three different branches of government to develop large, new, duplicate staffs of civil servants to process health claims.

A buffer is defined as a soft object which absorbs the shock of a collision between two harder objects. This is the role of the carrier—to act as a buffer between government and the "provider of service."

Advantages for Government

The presence of the carrier has advantages for both parties. For the government it removes the need for a new bureau which, once it had attained full growth, probably would be rigidly fixed in size. Blue Shield operates on a 30-day-cancellation contract under Medi-Cal, and a year-to-year contract under Medicare. If performance by the carrier, is unsatisfactory, the government may simply change to a different one, without encountering the almost impossible task of dismantling a large civil service bureau. The advantage to government of the efficiency of claims processing by experienced personnel has been noted already.

Another advantage to government is the fact that there need be no direct dealings with the various providers. Since the government agencies have had no such dealings in the past, misunderstandings would be even more common if carriers were not used. The resultant communications (some of which might be expected to be vituperative) would also be distributed to the Legislature and Congress, as well as to the Executive Branch, with further headaches for the agencies. When using carriers, there are also fewer direct dealings by government with the program beneficiaries, which reduces the chances of similar misunderstandings.

For the government and the taxpayer, a carrier is valuable as an organization which has a genuine interest in keeping down the cost of the programs since any increase in health care costs is also reflected in the carrier's own standard insurance programs. No carrier that did not have a significant amount of standard business with which to be concerned was selected under Medicare.

A similar advantage to government, particularly in the case of Blue Shield, has been the existence of a well-functioning, active, and aggressive peer-review mechanism — the medical advisors, and medical society county review committees. This too insures a further careful surveillance and control of health care costs.

Advantages for the Provider

One advantage to the provider of services is that he need not deal directly with the government. No single provider can ever feel anything other than smothered by the very size of government. With the help of the carrier, however, he can have his problems heard and make his protest felt, since the carrier has a friendly ear — Blue Shield is most anxious to maintain excellent physician relations, and will defend and protect the provider of service as well as the patient.

Another advantage to the provider is that he deals with the same office and the same people, through long established mechanisms, for all of his claims problems, government and private. He does not need to deal with many different systems. The forms devised by the carrier are simple and are similar to those he has used for years, quite different from the complicated ones devised by less experienced persons in government—for example, CHAMPUS.

Again, the carrier has knowledge of the cost payment statistics. Therefore, when it happens that figures are published, such as those alleging 1,200 California physicians had received $70,000 apiece from Medi-Cal, the carrier is in a position to refute the allegation and to release the facts. This would be impossible if only government agencies had access to these statistics.

An advantage for both parties is that the carrier is an interpreter of government regulations to the provider, and vice versa. Much time has been spent by many officials of Blue Shield discussing with government officials the reasons why some apparently logical ways of economizing on physicians' payments would do nothing more than harass already overworked doctors without

†Civilian Health and Medical Programs, U.S.

in any way improving the quality of care or lowering the program cost. Much more time has been spent trying to make government regulations intelligible to those who actually deliver health care.

Problems of the Carrier

The role of a buffer is not an easy one, nor did anyone expect it to be. In California, Medi-Cal has presented enormous problems — such as that of attempting to find out from the state which patients are actually eligible for welfare medical benefits. After two years this is still not satisfactorily resolved. Other problems include the task of explaining the programs to physicians who did not see the need for such a law in the first place, the enormous size of the programs, and the almost incredible amount of correspondence made necessary by both the size and the complexity of Medi-Cal. These are only four of many. Taken altogether, they have made many persons working for Blue Shield less happy about the use of a carrier than is either of the other two parties.

For all of these reasons, Blue Shield is vitally interested in constantly improving the Medicare and Medi-Cal Programs, many features of which were enacted without sufficient research and experience.

Through the strong link with the California Medical Association, Blue Shield is deeply interested in quality medical care, whether privately or government financed. Blue Shield is also interested in claims cost stabilization. Since some inflation in costs is inevitable with the rises in salaries of office nurses, laboratory technicians, x-ray technicians and the like, health care cost control will have to come through new and better ways of delivering this health care, rather than simply by arbitrary attempts to limit fee payments. Blue Shield is helping to finance some of these studies and the Blue Shield Research Department has already made a number of suggestions, several of which have been implemented and more of which are ready to be instituted. Because of its interest, its experience and its capable personnel, Blue Shield is better able to innovate improvements than is any government agency. The present system is far from ideal, but as long as free enterprise is represented by the carrier, the physician has a strong mechanism through which he can lead the way to constantly improving these government programs. The carrier will act as a catalyst in the developing of new and better ways of providing health care for the people of the United States.

Who needs the services of a carrier? Everyone — government, physician, taxpayer and patient.